
Archival Featured Article

Loneliness, Self-Consciousness, and PTSD: A Therapist's Diary

Ben Mijuskovic¹

¹ Departments of Philosophy and Humanities; California State University at Dominguez Hills; Carson, California, USA

Correspondence: Ben Mijuskovic (ruthben@roadrunner.com)

ABSTRACT - Posttraumatic Stress Disorder (PTSD) may represent the most extreme manifestation of loneliness, distinguished by its enduring intensity, emotional paralysis, and deep sense of abandonment and betrayal. In incest-related trauma, these dynamics are intensified as the collapse of intimacy and trust creates an existential isolation inseparable from the disorder itself. This essay examines a clinical case in which the victim's inability to meet the unrealistic and coercive demands of her father destroyed her capacity for agency and hope. The analysis highlights how conceptual understanding alone fails to overcome the immobilization that follows profound betrayal. Healing, therefore, requires not only cognitive insight but the gradual reestablishment of trust in others, which fosters renewed self-trust and emotional coherence. PTSD, in this view, emerges as both a disorder of trauma and of profound disconnection from the interpersonal foundations of meaning and safety.

Keywords:
PTSD; Loneliness;
Betrayal trauma;
Incest; Trust; Trauma
recovery; Emotional
paralysis;
Interpersonal
isolation

Elsewhere (Mijuskovic, 1990, 2005, 2012), I argue that after the biological needs of air, water, food, and sleep are met, the psychological drive to avoid loneliness and seek intimacy is the most powerful instinct in all human beings. Secondly, as opposed to other researchers on loneliness, who contend that loneliness is caused by external conditions—environmental, cultural,

ISSN:
1541-745X (Print)
2169-3951 (Online)

Editor's note: This article is a reprint of an original work published in 2014 in *Psychology Journal*, Vol. 11(1), pp. 44-53.



©2014/2021 IDR Ltd Co. This is an open access article under the Creative Commons Attribution 4.0 International License (<https://creativecommons.org/licenses/by/4.0/>).

situational, and even due to chemical imbalances in the brain—and hence transient and avoidable—by contrast, I hold that it is due to the innate activities and structures of human self-consciousness and therefore universal, permanent, unavoidable and that it influences all we feel, think, and do. For cognitive behavioral therapy, the criterion of therapeutic success is measured by improved behavior. By contrast, for psychodynamic treatment approaches, the standard of improvement is insight.

In the following essay, I have elected to discuss PTSD as a special case of loneliness—probably the most extreme form of social loneliness, as opposed to solitary confinement—because of the intensity of its enfolded issues, especially feelings of abandonment, betrayal, and the violation of trust issues. Thus, although *all* experiences of loneliness, to a lesser or greater degree, involve the same dynamic elements, in the case of PTSD they appear to be the most intense. In what follows, I shall try to weave a fabric of discourse, which incorporates my own impressions of a client, as well as the narrative of a PTSD victim, and both of these against the background of conflicting therapeutic principles in regard to the disorder. The subject of this essay, Sherry (not her real name), has given full consent to the writing and publication of this article.

I first met Sherry when I gathered her from our waiting room; I noticed she was attractive, slender, with long brown hair, dressed very casually, and I already knew by consulting the clinic's prior "episode screen" that she had not been treated previously, at least not in our large County mental health system. Once we entered my office, after only a few minutes, she began to sob loudly, almost hysterically, which startled me. But it wasn't the crying; that I was used to; but rather the articulate verbal expressions that accompanied her emotions. Shortly into the session, she started to tell me about her personal history. But no sooner had we started discussing her reason for coming and her symptoms than she disclosed with great emotion—mostly anger—that she was a victim of molestation as a young child and that she had been subjected to incestuous relations by her father from the ages of six to eight. And although she was clearly overwrought with emotion, what seemed so unusual to me was the "logical" continuity of her monologue. It was this essential feature of her character that to this day continues to impress me the most, her tendency to tell a story rather than simply vent, was highly unusual. Her memories hung together in a clear narrative form that transfixed my attention and made it so much easier for me to understand why she was so hurt and so angry at what had happened to her. It wasn't simply her anger and tears, but rather her recounting of the events, which were actually couched in terms of a moral complaint, in charges of abandonment and betrayal by her father; it was her sense of "righteous indignation" that made me think that perhaps she was going to be alright. Certainly she was a victim but she also wanted to fight back. How realistic this early "clinical judgment" was, I couldn't tell at the time of the first interview.

A major part of the clinic's formal assessment consists in taking a "bio-psycho-social history," which under the circumstances was difficult because she was under enormous pressure to get to what she was feeling, to what had been festering for so long and seemingly remained unexpressed in a clinical setting until now. She was twenty years old and Hispanic. I did manage to learn some family history but not much. I learned she has a sister four years her junior and they both lived at the time of our first appointment with their mother in low income housing. She also had an older

step-brother, her senior by eight years, married to a woman with three children (not his) who had been removed from her custody by Child Protective Services.

She had only reached the tenth grade before she dropped out of school to work sporadically selling lollipops at first and later cosmetics on the streets of downtown Los Angeles, the proceeds of which she dutifully gave to her mother.

Under the intense circumstances of her mental condition and the absorbing interest I had taken in spite of my “professional” self, I very much wanted to keep her case. At the close of the session, I asked her if she preferred a female therapist and she replied that she felt comfortable with me. We arranged to meet on a weekly basis. At the end of our meeting she hugged me. That sealed it for me. It was only later that she confided that one of the things that reassured her about me was that I didn’t press her on the details of the sexual abuse itself as other counselors had done and how upset she had been when, during the original criminal investigation, a social worker used two anatomically correct toy dogs with anal and oral orifices in her interview. She also commented that I didn’t suggest that I “understood” how she felt, as sometimes therapists tend to do.

During the first five years of her life, Sherry remembers how pleasant everything was. She belonged to two very large extended families and her weekends were consumed by large get-togethers; playing with the neighborhood children; and delighting in various activities with friends. She recalled how her father was respected and even admired by family and neighbors alike; and he was the main provider and protector of his family. Everything changed when the molestations began. Her sense of trust in her father, and even in the world around her, radically altered. In many ways, her story is a tale of trust lost; whether it can be reclaimed; and if so, how?

“At first, I didn’t know anything was wrong. He called me his ‘little princess’ and he bought me things, candy, and gifts. But then he started telling me that I shouldn’t tell anyone what we were doing. And if we weren’t doing anything wrong, why shouldn’t I tell my mother? And then he started threatening me, saying he would hurt me. After he was arrested, my mother found all kinds of porn magazines with men and sexual pictures of children in them.”

At our clinic, as well as all of the other County clinics in our mental health system, we are only allowed to use cognitive behavioral therapy as an intervention and we are required to formulate treatment contracts with the clients that are “objective”: specific, measurable, attainable, realistic, and time limited (SMART). This directive is strictly enforced by our weekly Quality Assurance reviews of all charts and our MediCal funding is disallowed if we are out of compliance. Accordingly, guided by her symptoms, and our clinic restrictions, I gave her a diagnosis of Post Traumatic Stress Disorder (309.81) along with Major Depressive Disorder (296.33). She sometimes used alcohol (beer) when she was depressed but usually she only drank with her former boyfriend. She was not a “solitary” drinker. As far as an objective goal was concerned, we “contracted” to focus on her finishing high school. Although this was the ostensible goal, the real and underlying subjective goal was not so much the reduction or elimination of the PTSD and depressive symptoms but rather the restoration of a sense of trust in individuals. The prior

“diagnostic” symptoms, I believed, would naturally diminish with the improvement in the trust issue. For me, two of the most hopeful signs of health in Sherry were that she *wanted* to be able to trust people; and she also declared early on a wish to some day have children. By contrast, many of my clients state that they cannot trust *anyone*. (Ironically enough, these same clients frequently and paradoxically claim that *they* can be trusted.) And the fact that she wanted children meant that she had the capacity for creating and caring for “something” beyond her self. These were both hopeful, positive indicators.

It’s important to point out that methodologically CBT therapy is intended to be behaviorally- and presently-oriented; committed to short term goals; focused on immediate, concrete behaviors that are “objectively” and “scientifically” determinable—indeed that *all* human behavior is determined and theoretically predictable in principle--and relatively inexpensive. By contrast “talk” therapy in general, and psychoanalysis in particular, is criticized by the behavioral proponents for being insight- and past-oriented; committed often to interminable treatment; focused on vague, long forgotten thoughts; inconclusive outcomes; subjective criteria of success; and expensive. *In short, that quantitative factors trump qualitative features.* As our sessions progressed, I learned that her mother was born in Mexico, had two brothers, one who systematically molested her, and a second male sibling who was developmentally delayed (Down’s syndrome). From what I could learn, it seems her mother was forced to assume the role of a “parentified child.” Because the father was ashamed of his afflicted son, he confined him to a closet-like room where he ate, went to the bathroom, and slept. At the age of sixteen, her mother decided to leave home and took her disabled brother with her with the intent of crossing the border into the US. Tragically, as it turned out, en route she was raped by five men and after crossing into California, the authorities took her and the brother into custody, separated them, but gave both of them sanctuary.

Sherry’s positive and forgiving attitude toward her mother at first puzzled me. She consistently declared the highest affection and regard for her mother and yet the two experienced constant and violent verbal arguments; their emotional conflicts were ferocious. This worried me because it was difficult for me to overlook the obvious negative codependency. Could not her mother, a victim herself of sexual violence, been more vigilant about her daughter’s vulnerability? I wondered if Sherry’s powerful fear of abandonment and loneliness was working against her instincts and she seemed unable to be critical of her mother’s failure to shelter her.

Later on in the sessions, I even suggested as much but she avoided the issue. I had been a Child Protective Services worker in San Diego for a couple of years and I was familiar with the concepts of a parent’s “failure to protect” as well as “enabling.” During our therapy sessions, she frequently complained that in order to impose control over her, the mother often enlisted the authority of the police to further her efforts at discipline through the courts. Indeed, only three weeks after I had opened Sherry’s case, her mother had her hospitalized as a “danger to self” on New Year’s Day as a form of managing her following an argument.

“My mother is always inconsistent. She doesn’t know how to show affection because of the way she was brought up. My mother never learned love. Her mother left my

grandfather when my mother was two years old and he wouldn't tell her where she lived. He forced her to work while he stayed home. It's scary to think how one minute she can love you so much and the next minute she hates you. And yet I suffer with her because of the things she suffered through in the past herself when she was young. I feel she is closer to my sister and she often tells me I remind her of my father. She once admitted she was only thinking of herself when she tried to kill herself. She is a selfish survivor. In the past, she left me with her sister because she told me she couldn't control me. She doesn't trust people. She has kicked me out of the house more than fifteen times and I resent her way of controlling me. We never talk about my father or what happened. But she believed me when I finally told her what happened. That's why I never blamed her for what happened. She acted as soon as I told her after she saw my sister playing with some dolls. When I have children, I will never let her babysit them alone. She's my mom and I need to have her around. I feel safe around her but not with her. She's the sort of person that could bring me to the floor and not care."

At the time of the molestations, both her parents worked, but there were often extended periods of time when Sherry was left alone with him and her infant sister. It was then that the incest occurred. She told of memories of how he would pin her down screaming and in the background she could hear children playing but they couldn't hear her cries. He would also threaten to leave the family and even hurt her if she disclosed what was happening. On one occasion, she confided to me that she wondered if she hadn't brought the incest on herself. I worried that in her natural fear of loneliness, to be loved, to be special, she had undermined her *own* ability to objectively evaluate her role and responsibility in what happened.

In Sherry's particular case, I tried to draw some specific distinctions. There is a clinical difference between conscious fear and unconscious anxiety. Phobias are always object- specific and concrete; it's not possible to make a mistake about what one is afraid of. And fears are treatable by a gentle, slow, safe, and graduated exposure to the feared object or situation, by desensitization. But clinical anxiety is far different. In Sherry's situation, it is grounded in unconscious *emotional* and violent conflicts between a self-protective narcissism and the terror of estrangement; love and disgust; security and abandonment; desire and pain; indulgence and abuse; inclusion with and exclusion from the world of the other significant self. It is a desire for nurturance set against a sense of loss of control in getting one's needs met. These are all positive struggles, desperate efforts to avoid loneliness. In cases of PTSD, however, the use of cognitive behavioral techniques, such as desensitization by forced sensory immersion, simulation, direct exposure, and "flooding," in an attempt to relive, re-visualize, re-experience the original trauma(s), doesn't work because it is a hybrid; it shares with fear a conscious element, namely the memory of the original trauma(s); but it also exhibits an unconscious dynamic (see especially DSM-IV PTSD criteria under C, 3-7).

And the conflict of intimacy *versus* loneliness is too extreme and above all too complex to respond to SMART interventions. It is not amenable to desensitization because the *dynamic* of the disorder penetrates to the very heart of the self's vulnerability, the fear of being absolutely

alone, feeling utterly abandoned and betrayed. It is an indelibly terrifying feeling and experience, a confrontation with the abyss of loneliness. As such, it leads readily into obsessive thoughts of constant danger and therefore avoidant behaviors. Sherry, for example, was unable to sleep on a bed that was raised off the floor for fear that someone might be hiding beneath; or when getting into a car, she always checked the back seat to see if someone might be hiding.

At the age of eight, the incest was finally discovered when her mother saw the younger daughter playing inappropriately with a pair of dolls. It was reported to the Department of Children's Services, investigated, and semen was found. The case went to trial. Sherry was taken out of school for six months so that she could testify. She told me that her father's side of the family harassed her mercilessly and accused her of lying. Nevertheless, she testified in court and he was sentenced to prison. At the age of ten, her mother attempted to commit suicide and Sherry described, during an early session, her sense of anger and fear over yet another betrayal and abandonment.

At the age of twelve, her mother took up with a man and went to live with him taking her younger daughter with her and left Sherry behind to stay with a maternal aunt. She also learned that after eight years in prison, her father was released, returned to Mexico, and started another family. All of these events greatly contributed to her increasing sense of estrangement and alienation and loss of trust. At the age of sixteen, Sherry started acting out, took up with a boyfriend, a relationship that intermittently lasted for four years, joined a gang, and was charged with a felony when she took the blame for her boyfriend because she was underage and she was sentenced to five months at a juvenile camp, only to find out that he cheated on her during her absence. At the camp, she met and liked one of the female counselors and expressed warm memories of the relationship. We tried to contact her without success.

Because of her emotional instability and failure to secure steady employment, one of my major efforts was to assist in filing for Supplemental Security Income benefits (SSI). Naturally, the question of psychiatric medication arose but she continued to insist she did not want to take meds. Nevertheless, because of the plan to apply for SSI, it seemed judicious to consult with one of our psychiatrists and seek a further supporting assessment that might prove helpful in her application. She saw the doctor and was prescribed both an anti-psychotic and anti-depressant, Seroquel and Zoloft. It's not unusual at our clinic for our medical staff to administer powerful drugs in order to induce sleep and rest even when there are no obvious psychotic symptoms present, neither hallucinations nor delusions. In any case, Sherry stopped medication early on. Like many of the clinic's clients, she complained the meds made her feel "foggy" and disoriented. A few months later, because I thought it would help her and hoping she was ready for group therapy, I began an anxiety therapy group with the intent of enlisting her participation because I was convinced that was where her strengths lay, namely in expressing her feelings, demonstrating her determination to get better, being supportive of others, and so on. Unfortunately, she was a frequent "no show," often came late when she did come, and after a short while, I realized that it was hard for her to share in an open forum. My concern was that I had unintentionally placed her in a difficult situation because of *my* expectations. I was insufficiently sensitive to her immediate practical needs and her deepest fears. She was chronically afraid of letting people down and I

wondered if perhaps her crippling anxiety was connected to the molest years when her father may have subjected her to idiosyncratic “performance” issues that were constantly changing and increasingly demanding. In other words, that maybe Freud’s “primal scene” dynamics were involved. But I never introduced this speculation before her. This was something that could only be uncovered by her own deeper self-conscious and intimate reflections.

Following another serious conflict with her mother and sister, which included a physical fight with her sibling, Sherry moved out of her mother’s home and went to live with her boyfriend, whom she had been dating for four years going back to the time of her gang affiliations. She told me the relationship was not physically intimate, that he only wished to promote her academic goals. Of course, the sexual aspect was only relevant to me in so far as it was either supportive and beneficial or destructive and abusive.

From the start, I was convinced Sherry desperately needed both physical closeness and psychological intimacy given the loneliness and abandonment issues she was struggling with. Then one day, she came to our session with some terrible bruises, swollen features on her face, and she showed me a large bruise on her side as well. She said she got involved in a physical altercation with her boyfriend’s sister, who was also staying with him at the time. Later, I discovered it was actually the boyfriend who had assaulted her. She had a strong tendency to withhold the complete truth from me because of embarrassment and then only later would she tell me the rest of it. At the same time, she disclosed that she was sexually involved with her boyfriend.

“A. took care of things. He was a man. He paid for me when we went out and he took good care of me. He stuck up for me if anyone criticized me. In the four years we were together, when I would leave him my Mom would take me in and when she would kick me out, he would take me back. It was like a tennis match; I would be hit back and forth, back and forth. But he had this thing his dad put on him. He told me ‘I hit you because I wanted to scare you so you wouldn’t leave me.’ He was like my mom that way. I would leave him and then come back. When we argued and he was mad at me, I would leave him and my mom would take advantage of the situation and offer to take me back. But I was always willing to pay the price of abuse to be with someone.”

Consistently, Sherry gravitated toward favoring male companionship above female friends and I wondered why that was the case. After all, her sexual and physical abuse had always been at the hands of males. And yet, I guessed that the “paradox” was solved by the fact that she believed only a male could protect her from other abusive males.

She moved out and for several months lived out of her car. She had earlier started taking Adult Education classes, but stopped going to class during this time and soon dropped out of school once more. Around Christmas time (2012), she had the misfortune of parking across a driveway and her car was impounded. The storage fees were so high she had no chance to retrieve the vehicle. She was now homeless, lonely, living on the streets, and this time her mother refused to take her back.

With the advantage of her SSI funding, the obvious task was to seek stable housing. In many ways, this had been an ongoing major necessity for her mental well-being all along. Without adequate housing nothing was going to work. The housing liaison at the clinic was an enormous help in that regard and working closely with Sherry she found her a small one-bedroom apartment in a decent neighborhood. Sherry gave the manager a down payment on the unit but on the day she was scheduled to move in, she balked and asked for her deposit back. She was reimbursed for half. Several weeks elapsed before she was able to find another unit. This one, however, was not in a safe environment because of the infiltration of gangs and within a couple of weeks she moved out and rented a room in a house some thirty miles from where she wanted to live on the basis that she thought a “fresh start” away from her mother might help. In fact, she always had a fear of being alone at night. Early on, I had urged her to consider living with a female roommate, both for safety and companionship reasons. And we even explored student housing at the large community college a few blocks down the street from our clinic. I also thought it would be therapeutic for motivational reasons for her to be in that sort of environment but she declined. She worried she would not be able to get along with a “stranger.”

Throughout our frequently interrupted weekly sessions, I began realizing that Sherry was experiencing a fundamental “disjunction” in relation to her cognitive *versus* her motivational factors. Conceptually she was quite capable of articulating long-term goals. For example, she declared she wanted to finish high school before her younger sister; but when it came time to act on her “intended” goals--volunteering, housing, education—she invariably pulled away. Choice is based on a combination of the two factors. Indeed, a psychiatrist in Germany, Michael Linden, proposes that in certain individuals suffering from extreme PTSD, when the damage has been especially severe, the sufferers become paralyzed from acting on their intentions, on their plans and goals. When the moment comes to move forward, they are immobilized by doubts and panic. Their sense of distrust in the world, in others, and even in themselves is so severe that they cannot move forward. He calls it PTED, Post Traumatic Embitterment Disorder. We recall that in Sherry’s case, she was doubly abandoned and betrayed, first by her father’s abuse but then also later by her mother’s suicide attempt as well as her later elopement with her younger sister.

In terms of the dynamics of PTSD, the pulsating heart of the disorder stems from the traumatic event(s) plus loss of trust. The traumatic source can be either natural and impersonal or highly personal. In the case of Hurricane Katrina, for example, it is impersonal, since it was a natural disaster beyond human control or intent. In the case of the Holocaust survivors, the source is impersonal in the sense that it is grounded in a complete loss of faith in *any* goodness in human nature. In the case of the Viet Nam war veterans, it is a loss of trust in their leaders. However, in Sherry’s case, it is intimately and intensely personal. That means the therapeutic strategies will be different in the four cases.

Frequently, during our sessions, Sherry would express her “wish” that her father would acknowledge what he did, assume responsibility for his actions, how he betrayed and injured her, essentially ruined her present life, and perhaps significantly destroyed her future chance for any happiness. Sometimes I would think that she was even capable of forgiving him had he done so. But he never did, he never once admitted his overwhelming complicity. He never protected her

from the false accusations of his family members during the court proceedings. Even after he was released from prison and went to Mexico, she even pondered writing to him in an attempt to achieve some sort of closure. To have been so important to him at such a critical and impressionable period of her life and then simply “thrown away,” discarded on what she described as a “pile of disinterest” brought her to the precipice of despair. Similarly, her mother remains equally at fault. She steadfastly refuses to discuss the past—the *why* of what transpired; the existential *meaning* of the doomed family relationships. This consistent refusal to address and acknowledge her daughter’s tragedy, her sense of isolation and loneliness from those she should have been closest to, to discuss her own neglect, her failure, her passivity, or any possible sense of personal guilt, shame, or neglect—and quite likely her jealousy of her daughter—weighs heavily on her child. To be “in it” all alone, without anyone to share the hurt, and to try to figure it out by herself is more than Sherry can bear. And even her sister owes her an incalculable debt for Sherry’s “sacrifice,” since it was her sibling who had been indirectly responsible for the exposure of the incest when she was observed by the mother playing manipulatively with a pair of dolls. Her sister has never been willing to talk about Sherry’s essentially protective sacrifice, although she has alluded to it often. After all, when we consider her behavior with the dolls, it seems clear the father had already introduced some sexual overtures toward her as well.

In recent psychoanalytic literature, there is a concept called “participatory witnessing.” It pertains to the *acknowledgment of the meaning* of a trauma, with all its ramifications and nuances, in both its affective and cognitive aspects and dimensions that are involved in such situations. It consists in an acknowledgment of complicity, what theologians frequently term “sins of omission.” This has never happened in the context of Sherry’s family situation thus leaving her in lonely despair.

At the beginning of this essay, I mentioned Sherry’s natural ability to verbally express herself in a persuasive and compelling narrative form or style. But as things now stand, her stories are disconnected from a critical self-understanding at the very core of her life by the refusal of the key participants to help her. Her distressing memories stand as isolated and solitary vignettes without the grounding of a unifying theme that ultimately connects them together: the incest itself and the role of the participants. Her stories function as brief photographic snippets without the context of a supportive canvas precisely because they lack the acknowledgment of those who are accountable, directly and indirectly, for her despair. There is an emptiness, an incompleteness, at the very heart and core of her painful lonely burden.

As Erikson stresses, the first and most critical stage of human development involves the issues of trust *versus* mistrust. Sherry had lost a great deal of faith in the intentions of others; she had essentially emotionally regressed to square one. In an article, “Loneliness and Intimacy” (Mijuskovic, 1990), I focused on the extensive studies conducted by psychoanalytic researchers, Anna Freud, Dorothy Burlingame, Margaret Ribble, Rene Spitz, John Bowlby, and Margaret Mahler, whose work emphasizes the tragedy of failed and lost trust. Before coming to Los Angeles, I had served for two years in San Diego County as a Child Protective Services social worker and I remember how often infants were removed at birth from their mother’s custody at the hospital when they showed with a positive toxicology screen. I remember the countless children of all ages

that were placed in the foster care system never to be reunited again with their natural parents. I recall all the acting out behaviors and the ensuing aggression and depression when they realized they were often doomed to continual placements, sentenced to be shuttled from foster parent to foster parent as they emotionally deteriorated. And I saw all this in Sherry's sad dark eyes: helplessness, hopelessness, and vulnerability.

The earliest writings on loneliness as a subject matter in its own right were written by two psychoanalysts, Gregory Zilboorg (1938) and Frieda Fromm-Reichmann (1959). Zilboorg argued for an essential progression from narcissism to loneliness and then hostility (culminating in suicide and homicide in extreme and pathological cases); and Fromm-Reichmann identified loneliness with both the inability to communicate and anxiety. These plausible connections prompted me to further explore the possibility that loneliness in the present instance involves a constellation of essential, interconnected feelings and thoughts within and intrinsic to Sherry's phenomenon. Thus, as our therapy sessions stumbled forward, punctuated both by frequent as well as prolonged absences, it became increasingly clear that the DSM-IV's simplistic and overly analytic diagnosis of PTSD fails to account for the complex constellation of feelings, thoughts, and imaginings underpinning Sherry's loneliness. Recalling her many expressions of distress, her deep ambivalence about her relationship to her mother, her likely unconscious resentment of her sister's survival at her expense, it became obvious that loneliness may be in reality an "umbrella" concept whose unfurled spokes include powerful undermining feelings of fear, shame, guilt, anger, anxiety, depression, isolation, revenge, remorse, incommunicability, abandonment, betrayal, longing, and so on. All these feelings and thoughts appear enmeshed in her. *And that is precisely why cognitive behavioral therapy is incapable in principle of addressing issues of loneliness, abandonment, and betrayal. It is reductively simplistic, lifeless, and one-dimensional. It fails to grasp what lies within. Loneliness is the genus while PTSD is only one of its species.*

The opposite of loneliness is intimacy; a sense of belonging to and with another self-conscious being. Intimacy itself depends on four conditions: (a) shared physical and temporal "proximity," "closeness" between selves; intimacy cannot occur at a distance; (b) *mutual* trust (in the Eriksonian sense); (c) *mutual* affection; and (d) *mutual* (age appropriate) respect. When these four conditions are met, then intimacy will have been achieved. More specifically, the key to intimacy is a *sharing* of feelings, thoughts, and values (Mijuskovic, 1990).

Thus, intimacy involves *trust*. But what is trust? What are the criteria of trust? How do we know that we can trust someone? Can we ever trust someone who has lied to us? In an intimate relationship, can we ever forgive someone who has committed adultery or betrayed us? To the question of trust, Sherry responded that you can trust someone if they are there for you when you need them. True. But you also have to be there for them when they need you. Or, perhaps as Kant expresses it: "Always treat the other person as an end in him/her self having infinite worth and never as a means to your own selfish goals." Intimacy, trust, and empathy are inseparably related (*a priori*). The latter consists in an intimate *concern*, a "care" for the other self; a "*feeling into*" the emotions of the other person (or even creature). It is a fusion of emotions and conceptions. As Aristotle describes it, it is one soul in two bodies. Obviously, there also must be a fulfilling

condition of *affection* of each person for the other, a genuine attraction, a quenching desire to be together. And, finally, there must be *respect*. In Sherry's case, the frequent violations by both her parents in terms of *not* respecting her feelings as a child--and now as a young woman--should alert her in the future to those that are emotionally dangerous to her. Her father exploited her sexually and her mother financially by her frequent and unfair appropriation of her earnings. As her mother had worked for her parent when she was young, so she expected her daughter to work as an adolescent at the expense of her education. But in any mutually supportive relationship, the person who has the most at stake in the decision should be the one to decide between alternative courses of action.

How are things currently with Sherry? I believe she has gained considerable *insight* and she has done so without medication. She is actively involved in our common enterprise of writing this essay and feels convinced that by expressing herself, getting "inside" herself, it contributes to a deeper self-understanding that can only be beneficial and strengthening. Her outlook is more positive; the frequent crying spells have diminished; she is attending individual therapy sessions more consistently; she has committed to a women's support group; renewed her vow to complete her high school work; returned to our area where she wants to live; and is finally on the verge of securing a small subsidized apartment with the help of our housing liaison. In addition, over the past two years, I think our relationship has been mutually rewarding and will continue to be so. For my part, I intend to remain committed to her well being and will do what I can to encourage her to be strong and to pursue her goal of helping others who have suffered similar fates. That's the healthy part of her; to care for some being beyond herself and thus escape her own destructive narcissism and isolation.

There is a critical difference between a *conception* and a *vision*. My greatest concern is that Sherry is still unable to connect her past to a viable vision of her future; that she cannot project an ideal of who she wants to be and do. Without that vision, she will remain undeveloped, static, and incomplete. Absent that vision, *commitment* is impossible; there is no *transcending* purpose. I frequently asked her about her daydreams and "centering" fantasies. And they are fairly restricted to the present, to earning enough money to treat herself to buying some nice clothes, going to a movie, enjoying a good meal in a restaurant, buying her mother a gift. I'm afraid that the future continues to frighten her. And yet, each night, she continues to be afraid of being all alone. Imagine being afraid of your physical surroundings to such an extent; afraid of going to sleep! That's the unfortunate legacy of her father.

In the foregoing, I have sought to convey a treatment paradigm that I believe successfully addresses PTSD with its exceptionally destructive nature. I have proposed that there is an underlying foundational loneliness discovered within PTSD--indeed that PTSD is actually a *species* of loneliness--that incorporates a multiplicity of feelings, meanings, and issues, which are intrinsically interlaced, and thus defy any simple and atomistic behavioral therapeutic techniques and/or present-oriented contractual interventions. Only a deeper self-conscious exploration achieving an insight into the stream of the temporal past can begin to elicit the understanding required to move forward and beyond the DSM's PTSD "disorder." Loneliness, I argue, is an "umbrella concept" that includes a large variety of negative emotions, all of which are included in

the narrower "diagnosis" of symptoms for PTSD. For example, the subject's conflicting unconscious feelings of affection and admiration for her mother set against the history of protective neglect and abandonment which can only be addressed by a painful journey into the past and the untangling of heretofore locked and impassible feelings that have to be first penetrated and subsequently meaningfully organized and unified into wholeness.

References

- Fromm-Reichmann, F. (1959). Loneliness. *Psychiatry: Journal for the Study of Interpersonal Processes*, 22(1), 1–15. <https://doi.org/10.1080/00332747.1959.11023153>
- Mijuskovic, B. (1977). Loneliness: An interdisciplinary approach. *Psychiatry: A Journal for the Study of Interpersonal Processes*, 40(2), 113–132. <https://doi.org/10.1080/00332747.1977.11023926>
- Mijuskovic, B. (1977a). Loneliness and a theory of consciousness. *Review of Existential Psychiatry and Psychology*, 15(1), 19–31.
- Mijuskovic, B. (1977b). Loneliness and the reflexivity of consciousness. *Psychocultural Review*, 1(2), 202–215.
- Mijuskovic, B. (1978). Loneliness and time-consciousness. *Philosophy Today*, 22(4), 276–286. <https://doi.org/10.5840/philtoday19782243>
- Mijuskovic, B. (1979–1980). Loneliness and narcissism. *Psychoanalytic Review*, 66(4), 479–492.
- Mijuskovic, B. (1981). Loneliness and human nature. *Psychological Perspectives: A Journal of Jungian Thought*, 12(1), 69–79. <https://doi.org/10.1080/00332928108408679>
- Mijuskovic, B. (1986). Loneliness, anxiety, hostility, and communication. *Child Study Journal*, 16(3), 227–240.
- Mijuskovic, B. (1988). Loneliness and adolescent alcoholism. *Adolescence*, 23(91), 503–516.
- Mijuskovic, B. (1990). Loneliness and intimacy. *Journal of Couples Therapy*, 1(3–4), 39–49.
- Mijuskovic, B. (2005). Theories of consciousness, therapy, and loneliness. *International Journal of Applied Philosophy*, 3(1), 1–18. <https://doi.org/10.5840/ijpp2005315>
- Mijuskovic, B. (2012). *Loneliness in philosophy, psychology, and literature*. Bloomington, IN: iUniverse.
- Zilboorg, G. (1938, January). Loneliness. *The Atlantic Monthly*, 45–54.